

Office of Administration  
Commissioner's Office

"Request for Preauthorization for Other Services"

Program: **Alternatives to Abortion**

Contractor: Nurses for Newborns

Subcontractor: N/A

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/provided to be reimbursed.

Client Name: [REDACTED]

Date Enrolled: \_\_\_\_\_

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
Due 3/20/17	Car Payment	\$247.76	Client has just returned to work & uses car to get to and from
AMOUNT TO BE REIMBURSED		\$247.76	

Please return to Alternatives to Abortion Program Manager, State of Missouri - Office of Administration, Commissioner's Office, State Capitol Building, Room, 125, Jefferson City, MO 65101. May be faxed to 573/751-1212 or emailed to [emily.kraft@oa.mo.gov](mailto:emily.kraft@oa.mo.gov) by the Contractor only!

Thank you.

Authorized person requesting purchase: Jenny Uhlig

Approved for purchase: Emily Kraft

Date 3/20/18

Purchase denied: \_\_\_\_\_

Date \_\_\_\_\_


Reason for denying purchase: \_\_\_\_\_

ni

## ALTERNATIVES TO ABORTION PROGRAM

### Assistance Request

*This form is to be completed by an NFN Nurse ONLY and must be completed entirely for timely approval and submission.*

DATE: 3/17/17 CLIENT NAME: 

*The above named client is requesting assistance through NFN's ATA Program for the following:*

☐ **Rent**  
(if new request, a W-9 and Lease MUST accompany this form)

☐ **Utility**  
(if Ameren, provide account number and account holder's name; if Laclede, provide bill)

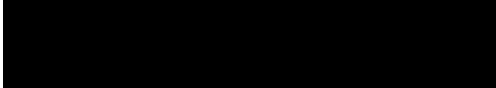
☒ **Transportation**  
(if new request, no additional information is needed; if repeat request for gas card ONLY, please provide receipts)

☐ **Other**  
(Pre-Authorization Request and documentation of the bill/invoice/etc. to be paid MUST accompany this form)

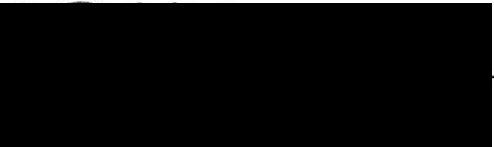
Landlord/Utility/Other NAME: Midwest Acceptance

BILL TOTAL: \$ 247.76 AMOUNT YOU ARE PAYING: \$ 40 AMOUNT REQUESTED: \$ 207.76

OTHER RESOURCES ATTEMPTED FOR ASSISTANCE (must list at least three):

1.  Agency Representative: \_\_\_\_\_
2. \_\_\_\_\_ Agency Representative: \_\_\_\_\_
3. \_\_\_\_\_ Agency Representative: \_\_\_\_\_

*I understand this is a one-time payment. This assistance is intended to assist you in the delivery of a healthy baby or in keeping your child on target developmentally. I have completed a **Budget Form** and **Individualized Pregnancy Continuation Plan (IPCP)** with my nurse in order to ensure my ability to pay*



3/17/17  
(date)

[Signature]  
(RN signature)

3/17/17  
(date)

IPCP Completed/Submitted: JU (initial)

Budget Form Completed: JU (initial)

Date Received: \_\_\_\_\_ Date Pledged/Submitted for Payment: \_\_\_\_\_